This form expires 2 years from the date of signature unless otherwise revoked before that time

HOPE419

PSYCHIATRY and COUNSELING

ASHLAND-ONTARIO-NORWALK-WOOSTER

419-951-2020 Phone/Fax

Hope419, LLC Authorization for Release of Information

******EVERY SECTION OF THIS FORM MUST BE COMPLETED TO BE ACCEPTED******

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

I authorize Hope 419 to exchange information with:

Name: _____

Address: _____

Phone: _____ Fax: _____

TYPE OF RECORDS AUTHORIZED:

Psychiatric/Psychological Evaluation and/or Treatment

☐ **ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY or**

The following SPECIFIC INFORMATION AUTHORIZED: (circle one or more as appropriate)

Insurance/billing information	Progress Notes	Laboratory Test tResults
Diagnostic Impression	Discharge Summary	Treatment Plans
Treatment Summary	Appointment scheduling/cancellations	

Other: (please describe)_____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Hope 419.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Hope419.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

NO DIGITAL SIGNATURES WILL BE ACCEPTED

Signature of Patient or Representative: _____ Date:_____

Printed Name of Person Signing Form:_____

Relationship to Patient (*if requester is not the patient)*: Parent- Legal Guardian- Other: _____

Signature of Patient (required if a minor age 13 or older) _____

Date_____